BlueCross BlueShield Nebraska

MEDICARE

Retiring with Confidence

Your Guide to Transitioning to Medicare

Retiring soon?

As you near retirement, you may receive a lot of information about the Medicare options available to you. While it might feel overwhelming at first, learning about Medicare doesn't need to be complicated.

Having served Nebraskans for more than 85 years, Blue Cross and Blue Shield of Nebraska (BCBSNE) can help you navigate every step of the process, so you can focus on the things you enjoy.

From the basics of Medicare to understanding when you can enroll, this guide is designed to provide detailed information about the many terms and topics you will hear as you transition to Medicare.

Ultimately, we want you to understand the choices and options available to you and feel prepared to make the decision that is best for you. Let's get started.

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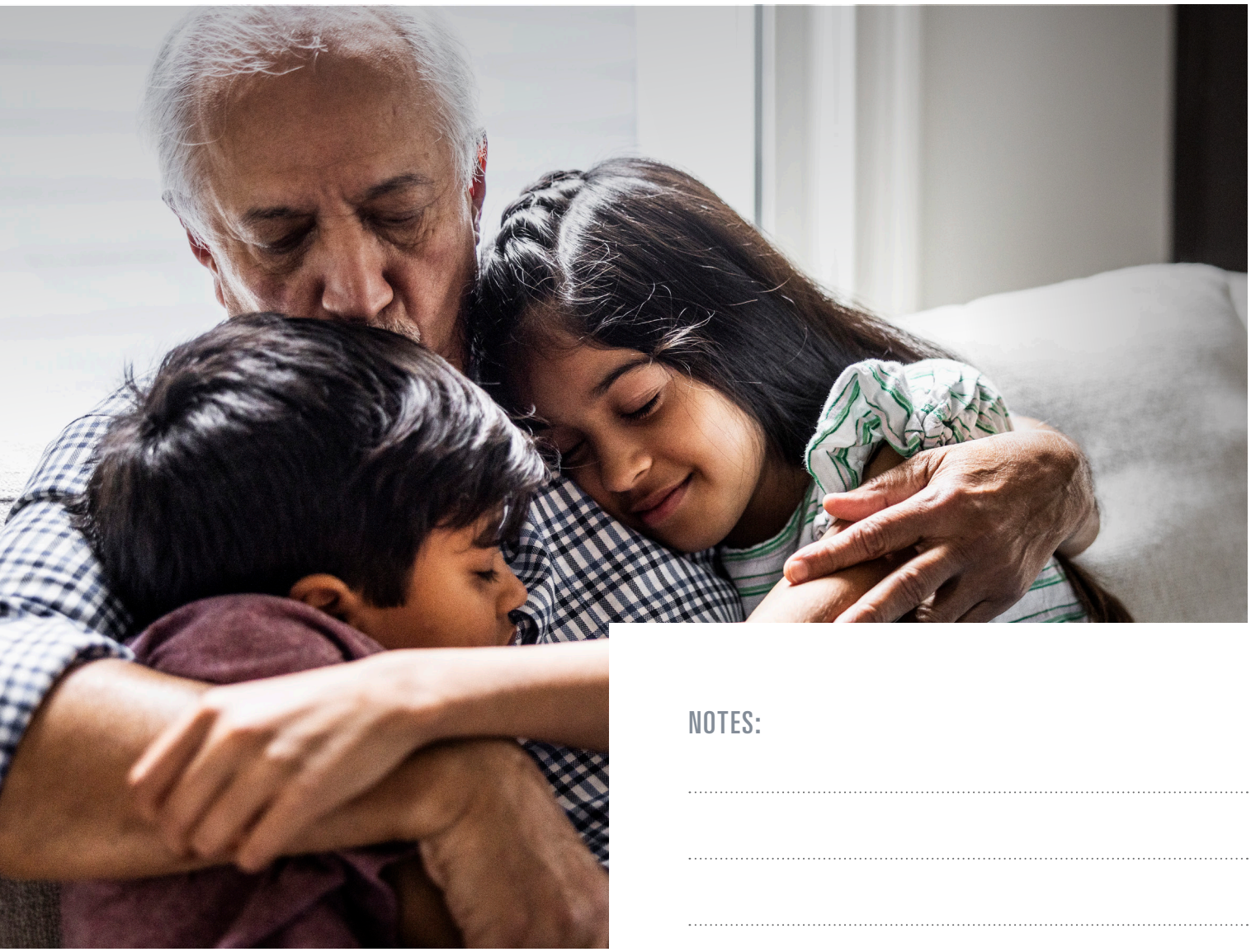
The Basics: What is Medicare?

Medicare is the federal health insurance program created in 1965 to provide health care coverage for Americans aged 65 years and older as well as the disabled. The program is administered by the Centers for Medicare and Medicaid Services (CMS).



NOTES:

THE BASICS:

Who is eligible for Medicare?

Medicare benefits are available to United States citizens and permanent legal residents who have resided in the United States for five consecutive years.

How do you become eligible?

- **By Age** – When you turn 65 years old
- **By Disability** – If you are under 65 and have received Social Security disability benefits for 24 consecutive months
- **By Medical Condition** – If you have been diagnosed with end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease

When can you enroll?

You may enroll or change your Medicare coverage during certain election periods, shown in the table below.

ELECTION PERIOD	WHEN	WHAT YOU CAN DO
Initial Enrollment Period (IEP)	Begins three months before you turn 65 and ends three months after you turn 65.	When you are first eligible for Medicare you have a seven-month initial enrollment period to sign up for Part A and/or Part B.
Annual Enrollment Period (AEP)	Each year, from Oct. 15 - Dec. 7	Make changes to your Medicare Advantage or Medicare Part D prescription drug coverage for the upcoming year.
Open Enrollment Period (OEP)	Each year, from Jan. 1 - March 31	A period directly following AEP when you are able to switch to a similar plan.
Special Enrollment Period (SEP)	A period of time when circumstances allow you to enroll in a Medicare Part D prescription drug plan and Medicare Advantage plan.	You can make changes to your Medicare Advantage and Medicare Part D prescription drug coverage when certain events happen in your life, like if you move or you lose other insurance coverage.

Late Retirees – As long as you are working full time, you have the option to delay enrolling in Part B of Medicare until you either go part time or retire completely, without being penalized. This also works if you are covered by your spouse's employer group coverage. Once you or your spouse retire, or you go part time, you will enter a SEP. Contact Social Security within 90 days of your retirement date to advise them that you will be retiring and determine your effective date of Medicare coverage.

ORIGINAL MEDICARE

The Parts of Medicare

Medicare Part A – Hospital Coverage

Part A of Medicare pays for hospital expenses. If you have been employed and have paid into the Medicare program through payroll taxes for a certain period of time (approximately ten years), you don't pay a premium for Part A coverage.

WHAT DOES MEDICARE PART A PROVIDE COVERAGE FOR?

Inpatient Hospital Care and Services

Skilled Nursing Facility Care

Home Health Care Services

Hospice Care

Inpatient Hospital Care and Services:

- There is a deductible for Medicare Part A
- The current Medicare deductible is $1,632 per benefit period*
  - If you go to a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins.
- Part A covers up to 90 days of inpatient hospital care each benefit period. Coinsurance (the amount paid after your Part A deductible is met) for a hospital stay is:

1-60 Days	$0 – Covered in full after the $1,632 deductible
61-90 Days	$408 per day
91+ Days	$816 per day for 60 lifetime reserve days**

After lifetime reserve days are used up, you pay all costs.

PREMIUM:

Generally, you will not pay a premium for Medicare Part A.

800-991-5650

Source: CMS.gov

Medicare Part A – continued

Skilled Nursing Facility

- This is not long-term care, but intermediate, rehabilitative coverage
- The skilled nursing facility must be Medicare-certified
- You are covered up to 100 days of skilled nursing care after a three-day hospital stay, as long as you entered the skilled nursing facility within 30 days of your discharge

Days 1-20	Covered in full, no deductible
Days 21-100	$204 per day
Day 100+	No coverage after day 100

Home Health Care

- Includes part-time or intermittent skilled nursing care, home health care, physical therapy, occupational therapy, speech-language pathology services and Medicare social services
- Does not include 24-hour-a-day care, meal delivery services, personal care or homemaker services
- Paid in full when ordered by a doctor and provided by a nurse and/or therapist from a Medicare-certified home health agency

Hospice Care

- Hospice services are paid for by Medicare and may include drugs to control symptoms and relieve pain, short-term respite care and home health services
- Care must be provided by a Medicare-approved hospice program
- You pay part of the cost for outpatient drugs and inpatient respite care

*__A Benefit Period__ begins the day you are admitted to the hospital and ends when you haven't received any inpatient hospital or skilled care for 60 days in a row.

**__Lifetime reserve days__ are additional days of coverage beyond day 90 in the hospital. You have 60 lifetime reserve days over your lifetime, meaning they can only be used once.

Source: CMS.gov

ORIGINAL MEDICARE

Medicare Part B – Medical Coverage

Part B of Medicare pays for medically necessary care you receive on an outpatient basis. While you may not pay a premium for Medicare Part A, you do have to pay a premium for Medicare Part B.

What does Medicare Part B provide coverage for?

Physician Services

Outpatient Care

Durable Medical Equipment

Laboratory Services

Preventive Care

- One-time routine physical exam within the first 12 months you are enrolled in Part B coverage (Welcome to Medicare Visit)
- Annual wellness exam
- Certain screening and immunizations at $0 cost

Deductible and Coinsurance

While Part A requires a per benefit period deductible, the Part B deductible is per calendar year. After you have met your deductible, you are responsible for coinsurance of 20%, which applies to most services. Additionally, **Medicare Part B does not have a "Stop Loss Limit." This means you will pay 20% of the balance due for any medical expenses. There is no limit, meaning after you meet your deductible you will always be responsible for 20% of the cost of most services.**

PREMIUM:

The Part B monthly premium is based on when you enroll and your annual household income. See "What will Medicare Cost me?" on page 14 for more information.

Source: CMS.gov

Original Medicare does not cover everything

Non-covered items include:

- All out-of-pocket costs – Beneficiary cost share with no out-of-pocket limit
- Up to 15% excess charges from "non-participating" providers
- Prescription Drugs
- Routine dental, vision and hearing care
- Corrective lenses or hearing aids

What will Medicare cost me?

There are many costs to take into consideration when making your decision about what Medicare plan options will work for you. Some, like your Part B premium, you will pay regardless of any private insurance coverage you select.

ADDITIONAL COSTS, LIKE SUPPLEMENTAL COVERAGE, MEDICARE PART D PRESCRIPTION DRUG COVERAGE, MEDICARE ADVANTAGE OR MAPD PREMIUMS WILL VARY DEPENDING ON THE PLAN SELECTED.

Source: Medicare.gov

Part B Premium

Your Part B premium is indexed based on your income. In most cases, if you don't sign up for Part B when you're first eligible, you will have to pay a late enrollment penalty. However, if you or your spouse continue to work after age 65, you may be able to delay Part B enrollment without a penalty. The late enrollment penalty means your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it. This penalty does not go away, and would be paid the entire time you have Part B.

If you don't sign up for Part B when you are first eligible, you also will have to wait until a General Enrollment Period (from Jan. 1 to March 31) to enroll in Part B. Part B coverage elected during the General Enrollment Period would start on July 1 of that year.

2023 Filing Status and Yearly Income			You pay each month (2025)
File individual tax return	File joint tax return	File married with separate returns	
$106K or less	$212K or less	$106K or less	$185
Above $106K up to $133K	Above $212K up to $266K	Not applicable	$259
Above $133K up to $167K	Above $266K up to $334K		$370
Above $167K up to $200K	Above $334K up to $400K		$480.90
Above $200K and less than $500K	Above $400K and less than $750K	Above $106K and less than $394K	$591.90
$500K or above	$750K and above	$394K and above	$628.90

Source: Medicare.gov

Medicare Part C – Medicare Advantage

Medicare Part C, also known as Medicare Advantage plans, combine Medicare Part A, Medicare Part B and often Medicare Part D into one plan. Many Part C plans provide coverage for things that Original Medicare does not, including prescription drugs, vision and dental care. These plans are offered by private insurance companies and approved by Medicare.

In order to enroll in a Medicare Advantage plan, you must first enroll in Original Medicare (Part A and Part B). You would then enroll in a Medicare Advantage plan through an insurance provider.

How Medicare Part C Works:

Service

Copays may apply for hospital and physician services

Post-Claim

Your insurance provider processes the claim and sends you an explanation of benefits indicating your financial responsibility (if any)

PREMIUM:

Part C has a monthly premium that varies depending on the benefits of the plan. Some plans offer a $0 premium option. These plans may include higher copayments or deductibles than other plans that offer a low monthly premium.

Eligibility Requirements:

- Must have Medicare Part A and Part B to enroll
- Must continue to pay Medicare Part B premiums (in addition to your Medicare Advantage premium)
- Must reside in the plan's service area

Medicare Advantage plans are offered by private insurance companies that are approved and regulated by Medicare each year and are required to follow Medicare guidelines. All Medicare Advantage plans have to offer benefits that are equal to or better than Original Medicare.

800-991-5650

Medicare Part C – continued

Benefits of Medicare Advantage:

- Usually, plans offer low or no premiums
- Premiums are the same for everybody regardless of age or health status
- Plans typically have lower copayments or deductibles than Original Medicare
- Plans include a maximum out-of-pocket limit that Original Medicare doesn't have, making spending more predictable
- Plans often include additional benefits like routine vision, hearing, dental and health club benefits

Preventive care services may cover:

- Welcome to Medicare Visit (one-time physical exam)
- Annual wellness visit
- Bone density test
- Diabetes
- Glaucoma
- Hepatitis C screening
- Cancer screenings
  - Colonoscopy
  - Mammogram
  - Pap smear
  - Prostate cancer screening
- $0 cost immunizations
  - Flu
  - Hepatitis B
  - Pneumococcal
  - Covid-19

Medicare Advantage Plan Types

Medicare Advantage plans offer benefits beyond Original Medicare. These plans are offered by private insurance companies and can be elected during AEP every year. Medicare Advantage plans that include Part D prescription drug coverage are called MAPD plans.

Medicare Advantage plans include:

- **Preferred Provider Organization (PPO) plans** require you to use doctors and hospitals in the plan's provider network in order to get the most out of your benefits. Referrals are not needed to see a doctor or specialist; however, you will likely have to pay more when you see an out-of-network provider.
- **Health Maintenance Organization (HMO) plans** have a network of doctors and hospitals. If you want to see a provider outside of the network, you may need a referral. Many HMO plans are now **Open Access** (see below); check with your plan to confirm what type of network access is included.
- **Private-fee-for-service (PFFS) plans** let you get care from any provider that agrees to accept the plan's terms and conditions of payment. The provider must also be eligible to provide services under Original Medicare.

What is an Open Access Health Plan?

Open Access health plans do not have a Primary Care Physician (PCP) requirement, which means specialist referrals are not required.

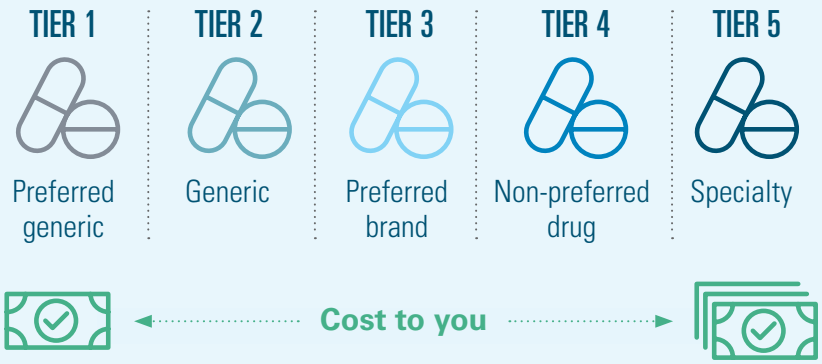
NOTES:

Medicare Part D – Prescription Drug Plans

Medicare Part D is an optional program to help you cover prescription costs. Prescription drug coverage is available to you in one of two ways: either through a Prescription Drug (Part D) plan or by enrolling in a Medicare Advantage plan that offers drug coverage. Both are available and delivered through private insurance companies that contract with Medicare. You must be enrolled in Medicare Part A and/or Part B to enroll in a prescription drug plan.

Individuals who choose to enroll in a Part D plan generally pay a monthly premium. Some plans may require a deductible. Part D covers drug prices at different tiers.

How Medicare Part D plans price drugs:



PREMIUM:

Monthly premiums vary from plan to plan. Each plan sets its premium for each calendar year. Cost assistance is available for those who qualify; also, a surcharge may apply to those with a higher income.

Late Retirees – As long as you are working full time, you have the option to delay enrolling in Part D of Medicare until you either go part time or retire completely without being penalized. However, if your current coverage is not considered credible, meaning equal to or better than the basic Medicare Part D benefit, you could incur a late enrollment penalty (LEP) for not enrolling when first eligible. This also works if you are covered by your spouse's group coverage. Special enrollment occurs when either you or your spouse retires, or you go part-time.

Contact Social Security within 90 days of your retirement date to advise them that you are going to be retiring and determine your effective date of Medicare coverage.

800-991-5650

Source: Medicare.gov

Part D Premium

Part D plans, which help with the cost of prescription drugs, have a monthly premium that you pay. If your income is above a certain limit, you will also pay an income-related monthly adjustment amount above your plan premium. If you do not elect Part D coverage when you are initially eligible you may incur a late enrollment penalty. This is calculated by multiplying 1% of the "national base beneficiary premium," which is $36.78 in 2025, by the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage.

2025 Filing Status and Yearly Income			You pay each month (2024)
File individual tax return	File joint tax return	File married with separate returns	
$106K or less	$212K or less	$106K or less	Your plan premium
Above $106K up to $133K	Above $212K up to $266K	Not applicable	$13.70 + plan premium
Above $133K up to $167K	Above $266K up to $334K		$35.30 + plan premium
Above $167K up to $200K	Above $334K up to $400K		$57.00 + plan premium
Above $200K and less than $500K	Above $400K and less than $750K	Above $106K and less than $394K	$78.60 + plan premium
$500K or above	$750K and above	$394K and above	$85.80 + plan premium

Late Retirees

If you meet certain conditions, such as maintaining creditable coverage under a group plan, you would be allowed to sign up for coverage during a SEP. This means you could delay Part B and/or Part D coverage and will not have to pay a late enrollment penalty.

PRESCRIPTIONS THAT I SHOULD MAKE SURE ARE COVERED INCLUDE:

Source: Medicare.gov

Medicare Supplement

Medicare Supplement

If you choose Original Medicare, Medicare Supplement plans (also known as Medigap plans) cover some of the health care costs left after Original Medicare pays. These plans are standardized, meaning the plan benefits do not change from year to year. These plans are sold by private insurance companies.

When to buy?

The best time to buy Medicare Supplement is during your six-month Medigap open enrollment period. During that time, you can buy any Medicare Supplement plan sold in your state, without answering any questions about your health.

Late Retirees

If you have group health coverage through an employer or union because either you or your spouse are currently working, you may want to wait to enroll in Medicare Part B and Medicare Supplement. When your employer coverage ends, you will get a chance to enroll in Part B without a late enrollment penalty. This would also mean your Medigap open enrollment period will start when you are ready to take advantage of it.

Keep in mind, as soon as you enroll in Part B, your Medigap open enrollment period starts. So, if you enroll in Part B while you still have employer coverage, you may miss your open enrollment period (where you can buy any Medicare Supplement plan without answering health questions) entirely.

MEDICARE SUPPLEMENT	VS	MEDICARE ADVANTAGE
Change your plan at any time as long as you are healthy enough to pass underwriting	VS	Change your plan once a year during the AEP, regardless of your health (see more information on page 13)
Nationwide coverage	VS	Networks (see page 10 for more detail)
Benefits remain the same from year to year	VS	Benefits may change from year to year
Premiums are based on age, gender, ZIP code and tobacco use	VS	Premium amounts are the same regardless of age, gender, ZIP code or tobacco use
Usually higher premiums than Medicare Advantage with lower out-of-pocket expenses when you get care	VS	Usually lower premiums than Medicare Supplement; however, you pay copayments when you get care
For prescription coverage, a separate Prescription Drug plan (Medicare Part D) is needed	VS	Most plans include health and prescription drug benefits under one low premium
Standardized plans mean you have access to the same benefits from all insurance companies	VS	Typically includes additional benefits not covered by Original Medicare, such as routine vision and hearing checks ups and gym memberships

Where can I get more coverage?

OPTION 1

Add one or both of the following to Original Medicare:

OR

OPTION 2

Choose a Medicare Advantage plan:

MEDICARE SUPPLEMENT INSURANCE (MEDIGAP)

Offered by private insurance companies

Helps pay some or all of the out-of-pocket costs not paid by Original Medicare

PRESCRIPTION DRUG (PART D) PLAN

Offered by private insurance companies

Helps pay for prescription drugs

MEDICARE ADVANTAGE (PART C) PLAN

Offered by private insurance companies

PART C
Combines Part A (hospital insurance) and Part B (medical insurance) in one plan

PART D
Usually includes prescription drug coverage

May offer additional benefits like vision and dental coverage

Know When can I enroll?

Initial Enrollment Period

You have a seven-month window to enroll, which includes the three months before you turn 65, the month you turn 65 and three months after you turn 65.

- You can sign up for Original Medicare (Part A and/or Part B)
- You can join private insurance plans such as Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug coverage

Annual Enrollment Period

Oct. 15 – Dec. 7, Annually

During AEP, you can:

- Join a Medicare Part D prescription drug plan or Medicare Advantage plan
- Change from Original Medicare to a Medicare Advantage plan
- Change from a Medicare Advantage plan back to Original Medicare
- Switch from one Medicare Advantage plan to another
- Switch from one Medicare Part D prescription drug plan to another
- Drop your Medicare Part D prescription drug plan

Medicare Open Enrollment

Jan. 1 – March 31, Annually

During the OEP, you can:

- Switch from one Medicare Advantage plan to another
- Disenroll from your Medicare Advantage plan and return to Original Medicare
  - If so, you will be able to join a Medicare Part D prescription drug plan

During OEP, you cannot:

- Switch from Original Medicare to a Medicare Advantage plan
- Join a Medicare Part D prescription drug plan if you are enrolled in Original Medicare
- Switch from one Medicare Part D prescription drug plan to another
- Switch from a Medicare Supplement plan to a Medicare Advantage plan

Special Enrollment Period

60-90 days / When circumstances allow you to enroll in a Medicare Part D prescription drug plan or Medicare Advantage plan

You might qualify for a SEP if:

- You are eligible for financial help from Social Security or your state
- You move outside of your current plan's service area
- Your current plan goes out of business
- You lose prescription drug coverage from an employer or union, or your drug coverage is no longer as good as the standard Part D benefit

Frequently Asked Questions

Do I need a physical exam to qualify for Medicare?

No. You must be 65 or older, under age 65 with a disability or meet other requirements.

Can I get Medicare even if I have a pre-existing condition?

Yes, you can enroll in Medicare and receive benefits no matter what your health status is or what pre-existing conditions you may have. Also, you will not be charged higher premiums because of past or current health conditions.

Which Medicare health plan is right for me?

It depends on what you need from a health plan and how much you can afford to pay. Consider these questions:

- If you travel often or for several months each year, will your health plan cover you in other parts of the country?
- Can you afford the plan's monthly premium? What are the plan's cost sharing and out-of-pocket maximum?
- Do you want a plan with drug coverage or do you prefer a stand-alone drug plan?
- Are you okay with benefits and/or cost sharing that may change each year? Or do you want a plan with benefits that do not change from year to year?

Do Medicare rates and deductibles change? How will I learn about changes?

Medicare rates and deductibles do change each fall for the upcoming year. Medicare members are notified by mail before AEP.

What if I don't join a Part D prescription drug plan?

Generally, you will pay the lowest monthly premium if you join during your seven-month Initial Enrollment Period. If you do not enroll and do not already have drug coverage that is as good as the standard Part D drug plan, you may have to pay a penalty in the form of a higher monthly premium when you enroll later. The longer you wait to enroll, the greater the penalty. You must pay this higher premium as long as you have Part D drug coverage.

What if I can't afford Medicare?

If you have limited income and resources, you may be able to get extra help to pay for your Medicare plan premium and costs.

To learn if you qualify for extra help, call:

- **800-MEDICARE (800-633-4227)**. TTY users should call 877-486-2048, 24 hours a day, seven days a week;
- The Social Security office at **800-772-1213** between 8 a.m. and 7 p.m. CT, Monday through Friday, TTY users should call **800-325-0778**; or
- Your state Medicaid office

How do I keep up with changes to Medicare as a result of the Affordable Care Act?

For information about Medicare benefits and services, call: **800-MEDICARE (800-633-4227)**, TTY users call 877-486-2048, 24 hours a day, seven days a week or visit **Medicare.gov**

What is MACRA?

MACRA is the Medicare Access and CHIP Reauthorization Act of 2015. This law states that after Jan. 1, 2020, newly-eligible Medicare beneficiaries will not be able to purchase plans that cover the Part B deductible. This includes Medicare Supplement Plan F (including High Deductible Plan F where available) and Plan C. Only people who are newly Medicare eligible on or after Jan. 1, 2020, will be impacted by this change. Newly eligible means that either you turn 65 on or after Jan. 1, 2020, or you become Medicare eligible due to a disability or end-stage renal disease on or after this date.

Glossary of Medicare Terms

Benefit period – For Original Medicare, the benefit period begins on the first day of a hospital stay and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Centers for Medicare and Medicaid Services (CMS) – The federal agency that runs Medicare and works with each state to run their Medicaid program.

Coinsurance – The percentage of the Medicare-approved amount you pay for a medical service. With some plans, you do not pay coinsurance until you have paid a deductible.

Copayment (copay) – A fixed amount you pay for each medical service, such as a doctor's visit. For example, a copayment might be $20 for a doctor's visit and $7 for a prescription drug you receive.

Cost sharing – The way Medicare and your health plan share your health care costs with you. Types of cost sharing you may pay include deductibles, coinsurance and copayments.

Deductible – A set amount of money you must pay before your plan pays. Usually, you have a separate deductible for Medicare Part A, Part B and Part D. Deductibles may also come with Medicare Advantage and Medicare Supplement plans.

Eligible care – Medical care and services that qualify to be covered by your health plan.

Lifetime reserve days – These are extra days that Original Medicare will pay for when you are in a hospital for more than 90 days. You have 60 lifetime reserve days to use during your lifetime and have a per-day copay when you use them.

Medicare Advantage – A Medicare health plan in which a private health plan manages your Medicare benefits. These are sometimes referred to as Medicare Part C. The most common types of Medicare Advantage plans are HMO, PPO and PFFS plans. Many Medicare Advantage plans may also offer Medicare prescription drug (MAPD) benefits.

Medicare Supplement (Medigap) plan – Health insurance policies that typically have standardized benefits and are sold by private insurance companies. Medicare Supplement plans work together with your Medicare Part A and Part B coverage. They generally allow you to go to any doctor or hospital that accepts Medicare.

Part D (prescription drug plan) – A Medicare Part D prescription drug plan may be either a stand-alone plan that you can enroll in if you have Original Medicare and/or a Medicare Supplement plan, or a Medicare Advantage plan that includes Part D coverage.

Premium – A fixed payment usually paid each month to be in a Medicare health plan or prescription drug plan.

Preventive care – Care that is provided to keep you healthy or find an illness or disease early, when it can be better treated. Examples of preventive care are flu shots, mammograms and screening for diabetes.

Important Terminology

Network pharmacies – Many of the Part D plans will now offer lower copayments for prescriptions at preferred pharmacies. This simply means they have negotiated a discounted rate for prescriptions at select pharmacies. Be sure to check with your drug carrier to see if they offer this option; this could mean additional savings to you by using a preferred pharmacy over a standard pharmacy.

Drug tiers – Drug tiers are defined as drugs that are placed into different tiers which have a different cost associated with each tier. Formerly known as generics or brand name drugs.

Formulary – A plan's list of covered medications, also known as a prescription drug list (PDL).

Formulary exceptions – A formulary exception is a drug plan's decision to cover a drug that's not on its formulary list or to waive a coverage rule. If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why the exception should be approved.

Preferred/standard pharmacy – Some plans offer a lower copayment at a preferred pharmacy.

Step therapy – You must try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.

Prior authorization – You and/or your prescriber must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it.

Quantity limits – Limits on how much medication you can get at a time.

For plan information please contact:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180

Call **800-991-5650**
Monday through Friday, 8 a.m. to 4:30 p.m. CT
TTY hearing-impaired users call **711**

Visit **Medicare.NebraskaBlue.com**

Email **GetStarted@NebraskaBlue.com**

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